Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: IRVING COPPELL SURGICAL HOSPITAL 400 W I-635 IRVING TX 75063	MFDR Tracking #: M4-11-1889-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: INDEMNITY INSURANCE CO Box #: 15	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as reflected on the Updated Table of Disputed Services: "payment received following MDR submission payment no equivalent to MAR amount"

Amount in Dispute: $16,428.28

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as reflected in the Supplemental MDR Response: "Enclosed please find the EOB for the date of service 8/20/10 along with the payment screen as proof of payment. Please be advised that not all services were paid as the Provider did not obtain preauthorization for all the surgical procedures performed, specifically CPT code 26446, 14020, and 25115. A copy of the preauthorization approval letter is also attached."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
08/20/10	Outpatient Services	$2,228.68 x 200% = $4,457.36 + $42.96 (Fee Schedule) = $4,500.32 – 6,083.69	$16,428.28	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on February 10, 2011.

The requestor submitted an updated table of disputed services on March 16, 2011.

On March 18, 2011 the respondent submitted an EOB showing reimbursement was made. The respondent also submitted a copy of the preauthorization approval for the date of service in dispute.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 247 – A payment or denial has already been recommended for this service.
   - 18 – Duplicate claim/service.
   - 306 – Billing is a duplicate of other services performed on same day.

- W1 – Workers Compensation State Fee Schedule adjustment.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
- 198 – Payment denied/reduced for exceeded precertification/authorization.
- 86 – Service performed was distinct or independent from other services performed on the same

2. Division rule at 28 TAC §134.403(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services are classified into groups called Ambulatory Payment Classifications (APCs). Services in each APC are clinically similar and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Packaged services are considered integral to the primary paid service and are not separately reimbursed. An OPPS payment status indicator is assigned to each HCPCS code. The status indicator for each HCPCS code is shown in OPPS Addendum B, and a full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year, both of which are publicly available from the Centers for Medicare and Medicaid services.

5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables was NOT requested by the requestor.

6. Although preauthorization was obtained In accordance with 28 TAC Section 134.600, the preauthorization approval lists CPT Code 25076, 25105 and 25295, billed under Revenue Code 360, as the codes listed on the preauthorization approval. No other codes billed under Revenue Code 360 were approved.

7. According to the requestors' updated table requestor shows that CPT Code 26449-F1 was paid $4,990.76; however, in reviewing the submitted EOB processed on 02/23/2011 this was not one of the codes included in the preauthorization and the EOB shows this reimbursement was made to CPT Code 25295-LT.

8. CPT Codes 26449-F2, 26449-F3, 26449-F4, 29449-F1-59, 29449-F2-59, 26449-F3-59, 26449-F4-59, 14020 and 25115-LT, all billed under Revenue Code 360, were denied using "198 – Payment denied/reduced for exceeded precertification/authorization. The respondent made no payments for these codes.

9. CPT Codes 25295-LT and 25295-LT-59, both billed under Revenue Code 360, were preauthorized services and reimbursable in accordance with Rule 134.403. These two codes are considered status "T" codes. Status "T" codes are outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. The APC rate for CPT Code 25295-LT is $2,912.82; the respondent paid $4,990.76. The APC rate for CPT Code 25295-LT-59 is $1,456.40; the respondent paid $945.00.

10. CPT Code 73090-TC billed under Revenue Code 320 is a status "X" code. Status "X" codes are ancillary services, paid as APCs rather than from a fee schedule. The APC rate for this code is $88.14; the respondent paid $89.80.

11. CPT Codes 36415, 82803 and 81002 are considered status "A" codes and are payable under a fee schedule or with a prospectively pre-determined rate. In accordance with Rule 134.203(c)(1) the combined Medicare total, including the Division conversion factor, for these codes is $42.96. The respondent paid $48.13.

12. According to Rule 134.203(b)(1) CPT Code 82800 is a Column II edit to Column I CPT Code 82803. A modifier is allowed; however, review of the bill shows a modifier was not attached. The respondent paid $10.00.

13. Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.403(f)(1)(A) as follows:

APC	Outlier Amount	Separate reimbursement for implantables WAS requested under Rule §134.403	APC X 200%	Fee Schedule (CMS x DWC conversion factor)	Less amount paid by Respondent	Additional amount due Requestor
$2,228.68	$0.00	$0.00	$4,457.36	$42.96	$6,083.69	$0.00

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307, §134.403, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

_____ _____ _____
Authorized Signature Medical Fee Dispute Resolution Date

_____ _____ _____
Authorized Signature Manager Medical Fee Dispute Resolution Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.